Dr. Steven P. Kraskow, D.C., P.A.

Chiro+Plus - 5205 E Kellogg Dr, Wichita, KS 67218 - 316-684-0550
InnerWorks - 3425 W Central Ave, Wichita, KS 67203 - 316-946-0990

Patient Data Sheet

Date_____

Name_____

Spouse Name _____

Married Single Divorced Widowed

Address_____

City_____State_____Zip_____

Home Phone_____Work Phone_____

Mobile Phone_____Email_____

Birth Date_____Age_____

S.S.# for Ins._____

Employment_____

Title_____

Duties_____

_____

Referred to our office by:

_____

Recreation Activities

Type	Freq / Wk	Intensity

Rehab / Diet Programs

Type	Freq / Wk	Intensity

Circle Insured or Responsible Party:

Self Spouse Parents

Work Comp Home Ins. Auto Ins.

Name_____

Address_____

City_____State_____Zip_____

Home Phone_____Work Phone_____

Birth Date_____Age_____

S.S.# for Ins._____

Claims #_____

Insurance Company_____

Person to Cotact_____

Employment_____

EMERGENCY CONTACT

Name_____

Phones_____

_____

Purpose of this appointment

_____

_____

_____

_____

_____

Medical History

List any accidents and falls you have ever had including work & auto:

Year

1._____

2._____

3._____

4._____

List any major surgeries you have ever had:

Year

1._____

2._____

3._____

4._____

List any fractures you have ever had:

1._____

2._____

3. _____

List major illnesses that you have had:

1._____

2._____

3._____

Medical Physician_____ ___
Town/Location_____ ___
Phone_____

Medical Physician_____
Town/Location_____
Phone_____

What is your general state of health? (Circle one) Excellent Good Fair Poor

When was the last time you really felt good? _____Weeks _____Months _____Years

What Medical diagnosis and medical treatment are you currently receiving?

1. Diagnosis_____ Treatment_____

2. Diagnosis_____ Treatment_____

3. Diagnosis_____ Treatment_____

Date of last Medical exam_____

What prompted exam_____

Date of last lab. work_____

Date of most recent X-rays_____

Body parts X-rayed_____

_____

Last Chiropractic treatment_____

Type of treatment_____

Name of Doctor_____

Location_____

Number of treatments_____

End Results? Good Fair Poor

Medical History

Four factors contribute to our state of health:

1. Mind / Body Neurological Integrity
2. Hormonal imbalances
3. Lifestyle activities
4. Hereditary weakness

Please provide the following information of your Grandparents, Parents, or Siblings

Have any of them had the following? G – P – S

_____ Allergies / Asthma / Crohns

_____ Mental Illness / Social Dysfunctions

_____ Cerebral Vascular Stroke

_____ Thyroid Disease

_____ Respiratory Disease / Emphysema

_____ Heart Disease / Murmurs

_____ Digestive Diseases / Ulcers / IBS

_____ Arthritis / Scoliosis / Spina Bifida

_____ Liver / Gall Bladder Disease

_____ Diabetes

_____ Kidney / Urinary Tract Dysfunctions

_____ High Blood Pressure

_____ Cancer / AIDS / HIV

_____ Multiple Sclerosis / ALS

Do you take any of the following?	NO__YES	More Details of Type	How Long?
Vitamin / Mineral Supplements			
Herbs / Laxatives			
Pain Meds / Muscle Relaxants			
Sedatives / Tranquilizers			
Birth Control Pills			
Hormone Replacement Therapy			
Blood Pressure Medicine			
Insulin			
Other Prescribed Medicine			
Over the Counter Products			
Recreational Drugs			
Tobacco			
Alcohol			
Coffee			
Diet Soda / Artificial Sweeteners			
Electric Blanket / Magnets			
Cell Phone / Pager			

NAME_____ DATE_____
DATE OF BIRTH_____ FILE#_____

SYMPTOM DESCRIPTION
_____
_____
_____
DATE FIRST NOTICED_____

ONSET SUDDEN RELATED TO ACCIDENT YES
GRADUAL NO

FREQUENCY OF PAIN
1. ONLY A RARE OCCURRENCE
2. A FEW HOURS PER DAY
3. MOST OF THE TIME
4. CONSTANT, NO REMISSION

QUALITY OF PAIN _____SHARP _____DULL _____BURNING
_____ITCHING _____DEEP _____SUPERFICIAL
_____NO PAIN INVOLVED

DOES THE PAIN RADIATE TO ANY WHERE ELSE? IF SO, TO WHERE?_____
_____
_____

IT IS BETTER WHEN I: SIT STAND LIE DOWN
REST EXERCISE
OTHER_____
_____

IT IS WORSE WHEN I: SIT STAND LIE DOWN
INACTIVE EXERCISE
OTHER_____
_____

HOW SEVERE IS THE SYMPTOM?
1. MILD ANNOYANCE
2. INTERFERES WITH SOME ACTIVITIES
3. INTERFERES WITH MOST ACTIVITIES
4. INTERFERES WITH ALL ACTIVITIES

_____

IS THERE A TIME OF THE DAY/MONTH/YEAR WHEN THE SYMPTOM IS WORSE? YES/NO
IF SO, WHEN?_____

PREVIOUS TREATMENT FOR THE ABOVE CONDITION_____
_____

STATEMENT OF FACTS ARE TRUE AND COMPLETE_____
(SIGNATURE OF PATIENT OR GUARDIAN)

Medicare Waiver of Liability
Advance Beneficiary Notice

This includes all services in our office throughout your treatment plan

Dr. Steven P. Kraskow, DC, PA
5205 E. Kellogg, Wichita, KS 67218
3425 W. Central, Wichita, KS 67203

PROVIDER NOTICE

"Medicare will only pay for services that they determine to be 'reasonable and necessary' under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service is not 'reasonable and necessary' under Medicare program standards, Medicare will deny payment for that service. I believe that in your case, Medicare is likely to deny payment.

BENEFICIARY AGREEMENT

"I have been notified by my provider that he/she believes that in my case Medicare is likely to deny payment for services. If Medicare denies payment, I agree to be personally and fully responsible for payment."

_____date_____
(Signature of Patient)

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Financial Policy

Office Fees:

- New Patient Evaluation / Doctor's Report / Initial Procedure $ 160
- Extended Evaluation / Progress Report / Optional Procedures $ 125
- Regular Evaluation / Progress Report / Continued Procedures $ 70
- Extended Procedure Time may be billed on the scale of $ 300 / hr
- On the first day of the month any unpaid balance over 60 days accrues interest at the rate of 1.5% per annum.

Insurance and Benefits Release:

I hereby authorize Doctor Kraskow to furnish my insurance carrier, benefits agent, attorney and any physician, any and all information regarding my health and treatment during any course of care. This includes copies of medical examination findings, x-ray reports, progress notes and my financial account.

I also authorize payment of the allowed benefits of insurance coverage for all services and fees directly to Dr. Kraskow, otherwise payable directly to me.

I agree to pay at the time of service the estimated percentage of the charges not covered by my primary insurance benefits.

I agree to pay at the time of service for charges that extend beyond my primary insurance referral benefits.

I understand that a reasonable effort will be made to secure payment from my benefit plan or primary insurance carrier through normal claims processing.

I promise to pay any unpaid balance within the next 30 days following the insurance company's response to the final charge on my account.

A copy of this authorization shall be considered to have the same validity as the original.

_____ _____

Patient Signature Date

Dr. Steven P. Kraskow, DC, PA

Privacy Notice Summary

1. **We understand that medical information about you is personal and we are committed to protecting medical information about you.**
2. **Our clinic employees are committed to protecting your personal health information and privacy.**
3. **We will use the information you provide to create records of your care and treatment required for billing of your insurance and by the laws of the Kansas Healing Arts Board.**
4. **We will safeguard your information and share it only with those who are entitled to know. We will obtain your permission for any other use or disclosure.**
5. **You may ask to see, or for a copy fee, obtain a copy of your file information.**
6. **If we have failed to maintain your privacy of your information you may file a formal complaint. For more details, please read this Privacy Notice.**

Privacy Notice

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THAT INFORMATION.
PLEASE READ THIS INFORMATION CAREFULLY.
IF YOU HAVE ANY QUESTIONS PLEASE REQUEST OUR PRIVACY OFFICER.

This Clinic provides health care to our patients in partnership with physicians in our group and other professionals involved in your care. Our Privacy Policy extends to:

- Any health care professional who treats you at any of our locations.
- All departments of our organization.
- All staff, student doctors or preceptor doctors.
- Any business associate or partner of this clinic with whom we need to share your health information.

We are required by law to:

- Keep medical and health information about you private.
- Provide you this notice of our legal duties and privacy practices regarding medical information about you.
- Follow the most stringent state or federal law.
- Abide by our currently published Privacy Notice.

We may change our policies at any time. Changes will apply to medical information that we already have. Before we make a significant change to our policies, we will change our notice and post the new notice in waiting areas, exam rooms and if applicable on our Web site. You can receive a copy of the current notice at any time. You will be offered a copy of the current notice at the time of your initial treatment. You will also be asked to acknowledge in writing you receipt of this notice.

How we may use and disclose health information about you.

1. We may use and disclose medical information about you for:
   a. Treatment – Sending information about you to another doctor as part of a referral.
   b. Payment – Sending billing information to your insurance company of Medicare.
   c. Health Care Operations – Using patient information for improving the quality of care.
2. We may use and disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give our medical information for public health purposes, abuse or neglect reporting, health audits or inspections, funeral arrangements, organ donation, worker's compensation reports, and emergencies. When required by law, information is provided in valid judicial or administrative orders.

3. We may also contact you for appointment reminders, or to tell you about possible treatment options, or alternative health related benefits or services that may be of interest to you.
4. We may disclose medical information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your condition.

Other uses of medical information.

- In any other situation not involving routine care, financial and insurance matters we will ask for your written authorization before using or disclosing medical information about you. If you choose later to revoke an authorization you may notify us in writing of your decision.

Your rights regarding medical information about you.

- In most cases, after you submit a written request you have the right to look at or get a copy of medical information that we use to make decisions about your care. We may charge a fee for the cost of copies and mailing supplies. If we deny your request to review or obtain copies, you may submit a written request for a review of that decision.
- If you believe that information in your record is incorrect or incomplete, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for the amendment. We could deny your request if the information was not created by us; if it is not part of the information maintained by us; or if we determine that the record is accurate. With a written request, you may appeal any decision by us to not amend a record.
- You have the right to a list of instances where we have disclosed medical information about you, which was not for treatment, payment, health care operations or where you specifically authorized a disclosure. The written request must state the time period desired for the accounting, which must be less than a six (6) year period starting April 14, 2003. The first disclosures list request in a twelve (12) month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.
- You may receive a paper copy of this Privacy Notice upon request of our privacy officer.
- You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location to communicate with you.
- You may request, in writing, that we not use or disclose medical information about you for treatment, payment, or health care operations, or to persons involved in your care except when specifically authorized by you, when required by law or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision on your request.

All written requests or appeals should be submitted to the Clinic Privacy Officer.

Complaints.

- If you wish to file a complaint because you feel that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer.
- Under no circumstances will you be penalized or retaliated against for filing a complaint.

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Effective date: April 14, 2003

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HIPAA AUTHORIZATION ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of the
Privacy Notice Summary.

Date: _____

Patient Name (Printed): _____

Patient Signature: _____

Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian,

Parent-if a minor): _____

Relationship: _____

Witness: _____